INCIDENT, INJURY OR DEATH REPORT

INSTRUCTIONS FOR COMPLETION OF THIS FORM

Return completed form to the address below:

Licensing and Certification Division
SUD Licensing and Certification Section
PO Box 997413, MS 2600
Sacramento, California 95899-7413
Email: LCDQuestions@dhcs.ca.gov

DO NOT LEAVE any questions, boxes, lines, or fields blank. Enter N/A if not applicable.

For hard-copy submissions:
The form and all supportive documentation must be printed single sided, with 12-point font on 8 1/2" by 11" white paper.
DO NOT USE staples on this form or on any attachments.
DO NOT SUBMIT doubled sided or bound documents.
DO NOT USE plastic sheets or page protectors, correction tape, white out, or highlighter pen or ink of a similar type on this form. If you must make corrections, please line through, date, and initial in ink.

PLEASE NOTE: Read all the instructions included on this form carefully and complete each item requested. For additional information regarding licensure of a residential alcoholism or drug abuse recovery or treatment facility providing alcoholism or drug abuse treatment or recovery services, please review Health and Safety Code section 11834.01 et seq. For additional information regarding the certification of an alcohol and other drug program providing alcohol and other drug (AOD) services, please review Health and Safety Code section 11832 et seq. This form can be used by licensed residential alcoholism or drug abuse recovery or treatment facilities and/or certified alcohol and other drug programs. Accordingly, terminology applicable for licensure (including “resident” and “facility”) and terminology applicable for certification (including “client” and “program”) are both referenced within this form.

The licensee or certified program shall report to the Department of Health Care Services Licensing and Certification Division **within one (1) working day**, either telephonically at (916) 322-2911 or electronically at LCDQuestions@dhcs.ca.gov any of the following events:

1. Death of any resident of the licensed facility from any cause even if the death did not occur at the licensed facility.
2. Death of any person that occurs at the licensed facility or certified program.
3. Injury of any resident/client at the facility/program that requires emergency medical treatment.
4. Cases of communicable disease reportable under Section 2500 and 2502 of Title 17, California Code of Regulations. These cases shall also be reported to the local health officer.
5. Poisonings.
6. Catastrophes such as flooding, tornado, earthquake, or any other natural disaster.
7. Fires or explosions which occur in or on the premises.

The telephonic report is to be followed by a written report to the Department within seven (7) calendar days of the event or incident. Please read all the instructions included on this form carefully and complete each item requested. For any questions regarding submitting this form, please contact the Officer of the Day at (916) 322-2911 or via email at LCDQuestions@DHCS.CA.gov. For additional information, please review the California Code of Regulations, Title 9, Division 4, Chapter 5, Subchapter 1 commencing with Section 10500 and the Alcohol and/or Other Drug Certification Standards 2.0 which outlines the requirements of an alcoholism or drug abuse recovery or treatment facility or treatment program.

SECTION A – TYPE OF REPORT

This section must be completed by all licensees or programs.

Check the appropriate box for the type of report you are submitting and complete the corresponding sections as described below:

Incident – To report an incident (i.e., poisonings; catastrophes such as flooding, tornado, earthquake, wildfires or any other natural disaster; fires or explosions which occur in or on the premises).

Injury Requiring Medical Emergency Treatment – To report an injury or change in medical condition of any resident or client, which requires emergency medical treatment.

Death – To report the death of any person that occurs at the licensed facility or certified program, and the death of any resident of the licensed facility, even if the death did not occur at the licensed facility.

SECTION B – FACILITY/PROGRAM INFORMATION

This section must be completed by all licensees or programs.

Facility or Program Name – Enter the name of the facility or program. Do not include the business entity name in this box unless the facility or program name is the same as the business entity name. Do not include the words or abbreviation for “Doing Business As,” unless you intend to use those words or the abbreviation in the facility or program’s name.

Facility License and/or Program Certification Number – Enter the facility or program license and/or certification number.

Facility or Program Street Address – Enter the physical address of the facility or program.

Room/Suite – Enter the room or suite number of the facility or program. If there are more than one, enter all rooms or suite numbers. If not applicable, enter N/A.

City – Enter the city of the facility or program.

State – This field is pre-filled to California. The Department only licenses facilities or certifies programs physically located in California.

Zip Code – Enter the zip code of the facility or program.

Business Phone Number – Enter the business phone number for the facility or program.

Information of Person Reporting Incident, Injury or Death

Name – Enter the first and last name of the person completing the report.

Title – Enter the title of the person completing the report (i.e., facility or program director, executive director, counselor, etc.).

Business Phone Number – Enter the business phone number of the person completing the report, including an extension, if any.

Business Email Address – Enter the business email address of the person completing the report.

Facility or Program Director Information

Name – Enter the first and last name of the facility or program director**.**

Business Phone Number – Enter the business phone number of the facility or program director, including an extension, if any.

Business Email Address – Enter the business email address of the facility or program director.

SECTION C – INCIDENT REPORT

This section must be completed if reporting an incident.

Date of Incident – Enter the date the incident occurred.

Time of Incident – Enter the time the incident occurred.

Narrative of Event – Please provide a narrative description of the incident. Please include as much detail as possible.

SECTION D – INJURY REQUIRING EMERGENCY MEDICAL TREATMENT REPORT

This section must be completed if reporting an injury requiring emergency medical treatment.

Name of Injured Resident or Client – Enter the first and last name of the injured resident or client.

Date of Injury – Enter the date the injury occurred.

Time of Injury – Enter the time the injury occurred.

Narrative of Event – Please provide a narrative description of the event that caused the injury requiring emergency medical treatment. Please include as much detail as possible.

SECTION E – DEATH REPORT

This section must be completed if reporting a death.

Name of Decedent – Enter the first and last name of the deceased person.

Check the appropriate box to describe the decedent.

Resident or Client – If the decedent was a resident or client at the facility or program, enter their date of admission into the facility or program.

Staff – If the decedent was a staff member of the facility or program, enter their title or position.

Other – If the decedent was neither a resident or client nor a facility or program staff member, describe the decedent's relationship to the facility or program and/or provide the persons of acquaintance at the facility or program.

Date of Death - Enter the date of death.

Time of Death - Enter the time of death.

Narrative of Event - Please provide a narrative description of the events leading up to and following the death that shall include, but not be limited to: the time, location, and nature of the event; a list of immediate actions that were taken, including persons contacted; and a description of the follow-up action that is planned to the extent possible, including steps taken to prevent a future death. Please include as much detail as possible.

DECLARATION

Print Name – Enter the first and last name of the individual signing the form.

Title – Enter the title of the individual signing the form.

Signature – Sign the form.

Date – Enter the date the form is signed.

SECTION A – TYPE OF REPORT
☐ Incident – Complete Sections B and C and Declaration
☐ Injury Requiring Emergency Medical Treatment - Complete Sections B and D and Declaration
☐ Death – Complete Sections B and E and Declaration

SECTION B – FACILITY/PROGRAM INFORMATION		
Facility/Program Name:		
Facility/Program License and/or Certification Number:		
Facility/Program Street Address:		Room/Suite:
City:	State: CALIFORNIA	Zip Code:
Business Phone Number:		
Information of Person Reporting Incident, Injury or Death		
Name:		Title:
Business Phone Number:		Business Email Address:
Facility/Program Director Information		
Name:		
Business Phone Number:		Business Email Address:

SECTION C – INCIDENT REPORT	
Date of Incident:	Time of Incident:
Narrative of Event:	

SECTION D – INJURY REQUIRING EMERGENCY MEDICAL TREATMENT REPORT	
Name of Injured Resident or Client:	
Date of Injury:	Time of Injury:
Narrative of Event:	

SECTION E – DEATH REPORT	
Name of Decedent:	
Select one of the following to describe decedent: ☐ Resident/Client Admission Date: ☐ Staff Title/position: ☐ Other Describe:	
Date of Death:	Time of Death:
Narrative of Event:	

DECLARATION	
I declare under penalty of perjury under the laws of the State of California that the foregoing information and any attachment is true, accurate and complete to the best of my knowledge and belief. I hereby further declare that I will comply with the statutes and regulations that govern the operation of this facility or program. I declare that I am authorized to sign this form.	
Print Name:	Title:
Signature:	Date:

PRIVACY NOTICE ON COLLECTION

The purpose of this form is to collect information for licensure or certification of residential alcoholism and drug abuse recovery or treatment facilities or treatment program or outpatient program. The information collected in this form is required by the Department of Health Care Services (Department), Licensing and Certification Division, Licensing and Certification Section by the authority of Health and Safety Code, Section 11834.01 et seq. and California Code of Regulations, Title 9, Division 4, Chapter 5 and the Alcohol and/or Other Drug Certification Standards 2.0. The personal information collected in this form is confidential and protected by the Information Practices Act (California Civil Code 1798, et seq.), Department policy, and state policy.

All information requested in this form is mandatory. Review of an application will be terminated for not supplying the mandatory information requested or supplying incomplete information. The Department may share provided information with other state agencies to perform its constitutional or statutory duties where the use is compatible with a purpose for which the information was collected. The Department may also share information with local, state, or federal government entities if required by state or federal law. Please do not provide any personal information other than the information that is specifically requested in this form.

In most cases, individuals have a right to access information about them that is in federal and state records. For more information or access to records containing your personal information maintained by the Department, contact the following:

Licensing and Certification Division
SUD Licensing and Certification Section
PO Box 997413, MS 2600
Sacramento, California 95899-7413
Tel: (916) 322-2911
Email: LCDQuestions@dhcs.ca.gov

The Department of Health Care Services' policies regarding personal information are available online in the Department's Notice of Privacy Practices (https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx) and the Privacy Policy Statement (https://www.dhcs.ca.gov/pages/privacy.aspx).